## ARMY HEALTH PROFESSIONS SCHOLARSHIP PROGRAM (HPSP)
## REPORT OF PERIODIC MEDICAL EXAMINATION

**This form must be submitted with MEDCOM Form 673-R (Application for Annual 45-Day Active Duty For Training (ADT) For Participants in the U.S. Army Health Professions Scholarship Program (HPSP)). ADT applications that are submitted without this form are considered incomplete. See DA Form 4571-R for Data Required by the Privacy Act of 1974.**

| 1. NAME (last, first, middle initial) | 2. SSN |
|---|---|
| | |

**3. ADT Location.**

**4. I underwent a medical examination on (enter date)_____at (enter medical treatment facility)_____. To the best of my knowledge (check the appropriate statement and use additional space as needed):**

**( ) There has been no significant change in my medical condition since the accomplishment of that medical examination.**

**( ) The following changes in my medical condition should be noted:_____**

| SIGNATURE | DATE |
|---|---|
| | |